Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: RELIEF MEDICAL SUPPLY 306 IVY WAY GARLAND TX 75043	MFDR Tracking #: M4-06-4549-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUNICIPAL LEAGUE INTERGOVERNMENTAL RISK Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The items issued to [Claimant] included: a TENS unit, hot/cold pack, conductive garment, and bio-freeze pain gel. These items used in conjunction are proven to be more effective. They are used to treat pain for musculeskeletal pain, acute posttraumatic pain, chronic and myofascial pain among much other disorders are treated. Many doctors use these items to treat patients with pain due to an injury." [sic]

Amount in Dispute: $2060.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Denial Code(s)	Amount in Dispute	Amount Due
3/10/2005	E0731-Cod Garm	50, W1, 108, B5, NU, W4, 940	$300.00	$300.00
3/10/2005	A9999-Hot Pack	940, B15, W4	$50.00	$0.00
3/10/2005 4/10/2005 5/10/2005 6/10/2005 7/10/2005 8/10/2005	E0745-EMS Rtl	50, W1, 108, B5, RR, W4, 940	$150.00/MO X 6 = $900.00	$671.34
3/10/2005 4/10/2005 5/10/2005 6/10/2005 7/10/2005 8/10/2005	E4595-EMS Pads	108, B15, W4	$85.00/MO X 6 = $510.00	$0.00
3/10/2005 4/10/2005 5/10/2005 6/10/2005 7/10/2005 8/10/2005	A4630-Rpl Batt	50, W1, B15, NU	$15.00/MO X 6 = $90.00	$46.86
3/10/2005 4/10/2005 5/10/2005	A9999-Pain Gel	108, B15	$35.00/MO X 6 = $210.00	$0.00

6/10/2005 7/10/2005 8/10/2005				
			Total Due:	$1018.20

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Division rule at 28 TAC §133.307 effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedures for health care providers to pursue a medical fee dispute.
2. Division rule at 28 TAC §134.202 effective August 1, 2003, sets out the fee guidelines for the reimbursement of workers' compensation professional medical services.
3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
5. Division rule at 28 TAC §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 5/3/2005
   - 50-Service not Deemed 'Medically Necessary' by payer.
   - RR-Rented Equipment.
   - NU-New Equipment.
   - W1-Workers' Compensation State Fee Schedule Adj.

   Explanation of benefits dated 9/14/2005
   - 108-Rent or Purchase Guidelines not Met.
   - NU-New Equipment.
   - B5-Pymnt Adj/Program guidelines not met or exceeded.
   - RR-Rented Equipment
   - W4-No additional payment allowed after review.

   Explanation of benefits dated 3/8/2006
   - 108-Rent or Purchase Guidelines not Met.
   - NU-New Equipment.
   - 940-Re-evlauation-no additional payment recommended.
   - RR-Rented Equipment
   - W4-No additional payment allowed after review.
   - B15-Procedure/Service is not paid separately.

Issues

1. Does a medical necessity issue exist in this dispute?
2. Did the requestor support the position that additional reimbursement is due for HCPCS codes E0731, E0745, E4595, A9999, and E4630?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent denied reimbursement for Durable Medical Equipment (DME) with EOB denial reason code "50-Service not Deemed 'Medically Necessary' by payer on the initial EOB. The Division finds that on the reconsideration EOBs, the respondent did not maintain this denial reason upon reconsideration. A review of Division records does not support a medical necessity issue exists; therefore, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. Division rule at 28 TAC §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical

services, Texas Workers' Compensation system participants shall apply the Medicare program methodologies, models, and values or weight including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."

- HCPCs code E0731 is described as "Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)". The requestor noted on the medical bill that HCPCS code E0731 was for "COD GARM." Per DMEPOS, HCPCS code E0731 has a fee of $303.19.
- HCPCS code A9999 is described as "Miscellaneous DME supply or accessory, not otherwise specified." The requestor noted on the medical bill that HCPCS code A9999 was for "HOTPACK" and "PAIN GEL". Neither the DMEPOS fee schedule nor the Texas Medicaid Fee Schedule has set a fee for HCPCS code A9999.
- HCPCS code E0745 is described as "Neuromuscular stimulator, electronic shock unit." Per DMEPOS, HCPCS code E0745 has a rental fee of $89.51.
- HCPCS code E4595 is described as "Gait trainer, pediatric size, posterior support, includes all accessories and components." The requestor noted on the medical bill that HCPCS code E4595 was for "EMS PADS". Neither the DMEPOS fee schedule nor the Texas Medicaid Fee Schedule has set a fee for HCPCS code E4595.
- HCPCs code A4630 is described as "Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient". The requestor noted on the medical bill that HCPCS code A4630 was for "RPL GEL." Per DMEPOS, HCPCS code A4630 has a fee of $6.25.

Division rule at 28 TAC §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The Division finds that HCPCS codes A9999 and E4595 do not have an established relative value and the insurance carrier did not submit documentation to support that the carrier has assigned a relative value.

Division rule at 28 TAC §134.202(d) states "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated and/or contracted between the provider and carrier for the disputed HCPCS codes A9999 and E4595; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate in accordance with Division rule at 28 TAC §134.1.

Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated for HCPCS codes A9999 and E4595.
- The requestor does not discuss or explain how payment of $50.00 and $35.00/mo for HCPCS code A9999 would result in a fair and reasonable reimbursement.
- The requestor does not discuss or explain how payment of $85.00/mo for HCPCS code E4595 would result in a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.

- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
- The requestor did not submit nationally recognized published relative value studies, published commission medical dispute decisions, or values assigned for services involving similar work and resource commitments.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for HCPCS codes A9999 and E4595. As a result $0.00 reimbursement is recommended for HCPCS codes A9999 and E4595. The requestor has supported reimbursement is due for HCPCS codes E0731, E0745 and A4630 per Division rule at 28 TAC §134.202(d).

3. Reimbursement will therefore be calculated according to Division rule at 28 TAC §134.202(c)(2), for HCPCS codes E0731, E0745 and A4630.

- Per DMEPOS, HCPCS code E0731 has a fee of $303.19 X 125% = MAR of $378.99. However, the requestor is seeking dispute resolution for $300.00. This amount minus previously paid of $0.00 = $300.00. This amount is recommended for reimbursement.
- Per DMEPOS, HCPCS code E0745 has a fee of $89.51/mo. The requestor is seeking dispute resolution for six (6) months; therefore, $89.51 X 125% = MAR of $111.89 X 6 months = $671.34. This amount minus previously paid of $0.00 = $671.34. This amount is recommended for reimbursement.
- Per DMEPOS, HCPCS code E0745 has a fee of $6.25. The requestor is seeking dispute resolution for six (6); therefore, $6.25 X 125% = MAR of $7.81 X 6 = $46.86. This amount minus previously paid of $0.00 = $46.86. This amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement for HCPCS codes E0731, E0745 and A4630. For the reasons stated above, the division finds that the requestor has not established that reimbursement is due for HCPCS codes A9999 and E4595. As a result, the amount ordered is $1018.20.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $1018.20 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

		1/6/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.